PRINTED: 03/30/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3170AGC 03/03/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1042 FEATHERWOOD AVE **FELIS CARE HOME** HENDERSON, NV 89015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey conducted in your facility on 3/3/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was six. Six resident files were reviewed and two employee files were reviewed. The facility received a re-survey grade of D. Y 103 449.200(1)(d) Personnel File - NAC 441A / Y 103 SS=E Tuberculosis NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(d) The health certificates required pursuant to chapter 441A of NAC for the employee.

This Regulation is not met as evidenced by: Based on record review on 3/3/10, the facility failed to ensure 1 of 3 employees complied with NAC 441A.375 regarding tuberculosis (TB)

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS3170AGC				B. WING		03/03/2010		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRE	SS, CITY, STA	TE, ZIP CODE			
FELIS CARE HOME			1042 FEATHERWOOD AVE HENDERSON, NV 89015					
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Y 103	Continued From page 1			Y 103				
	testing (Employee #2 failed to have evidence of a positive TB skin test).							
	This was a repeat deficiency from the 10/8/09 State Licensure survey. Severity: 2 Scope: 2							
Y 105 SS=E	449.200(1)(f) Personnel File - Background Check			Y 105				
	NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: Based on record review on 3/3/10 the facility failed to ensure 1 of 3 employees met background check requirements (Employee #3 fingerprints were not submitted to the Departmen of Public Safety).		ach lude:					
			#3					
	This was a repeat def State Licensure surve	ficiency from the 10/8/0	9					
	Severity: 2 Scope: 2	2						
Y 178 SS=F	449.209(5) Health and	d Sanitation-Maintain Ir	nt/Ext	Y 178				
	ensure that the premi	of a residential facility s ses are clean and that andscaping of the facili	the					

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Severity: 2

Scope: 3

Y 181 449.209(8) Health and Sanitation-Temperature SS=D

Y 181

NAC 449.209

8. The temperature of the facility must be maintained at a level that is not less than 68 degrees Fahrenheit and not more than 82 degrees Fahrenheit.

This Regulation is not met as evidenced by: Based on observation and interview on 3/3/10, the interior temperature of 1 of 5 bedrooms was 86.4 degrees (Bedroom #5).

Severity: 2 Scope: 1

NAC 449.2175

Y 272 449.2175(3) Service of Food - Menus

SS=C

Y 272

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| X1 | PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | (X4) DEFICIENCIES | (X5) DATE SURVEY COMPLETED | (X5) DA

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

FELIS CARE HOME		1042 FEATHERWOOD AVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI	=	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 272	Continued From page 3	Y 272		
	3. Menus must be in writing, planned a week advance, dated, posted and kept on file for 9 days.			
This Regulation is not met as evidenced to Based on observation and interview on 3/3 the facility failed to ensure a planned, date posted menu was utilized.		10,		
	Severity: 1 Scope: 3			
Y 273 SS=D	449.2175(4) Service of Food - Special Diets	Y 273		
	NAC 449.2175 4. A resident who has been placed on a specifiet by a physician or dietitian must be proving meal that complies with the diet. The administrator of the facility shall ensure that records of any modification to the menu to accommodate for special diets prescribed by physician or dietitian are kept on file for at lego days.	ded a		
	This Regulation is not met as evidenced by: Based on observation and interview on 3/3/1 the facility failed to provide a diabetic diet to 6 residents ordered a special diet (Resident	10, 1 of		
	Severity: 2 Scope: 1			
Y 371 SS=F	449.224(2) Housing for Staff Members	Y 371		
	NAC 449.224 2. Members of the staff of the facility and their families who live			

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill.

This Regulation is not met as evidenced by: Based on record review on 3/3/10, the facility did not ensure that monthly evacuation drills were conducted on an irregular schedule for the past 2

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	VIDER OR SUPPLIER	NVS3170AGC			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	VIDER OR SUPPLIER			B. WING		03/03/2010			
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EELIS CADE HOME			1042 FEAT	1042 FEATHERWOOD AVE IENDERSON, NV 89015					
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Y 434	Continued From page 5			Y 434					
C	of 12 months (Jan, and Feb of 2010).								
	This was a repeat deficiency from the 10/8/09 State Licensure survey.								
5	Severity: 2 Scope: 1								
SS=D N	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.		•	Y 444					
e e e e e e e e e e e e e e e e e e e	Based on record revie not ensure smoke det the past 12 months (F	iciency from the 10/8/0	y did ut of	Y 530					
1 (e t	NAC 449.260 (e) Provide for the residents at least 10 hours each week of scheduled activities that are suited to their interests and capacities. This Regulation is not met as evidenced by:								

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attached to or adjacent to a resident's body that cannot be removed easily by the resident and restricts the resident's freedom of movement or

Based on observation, interview and record review on 3/3/10, the facility failed to ensure 1 of

his normal access to his body.

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